CITIES OR CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ 19654

Reg. Diat. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, Institution, or street address where death occurred:

352 Gerard St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Havre de Grace, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 352 Gerard St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James A. Allen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie Allen

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Apr. 22, 1870

8. AGE:

Years	Months	Days	If less than one day
75	5	8	hrs. min.

9. Birthplace: N. Y.

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Mrs. Annie Allen

Address: 352 Gerard, St. City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 3, 1945 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: P. Madison Mitchell

Address: Havre de Grace, Md.

19. Oct. 2 1945 (Date rec'd by registrar) H. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30 1945 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Baltimore Md. Date signed: 9/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09055

CERTIFICATE OF DEATH

★ Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Harford

City or town: Monkton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Monkton (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War (one)

3. (a) FULL NAME Victor Harold Barrow

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary Gray

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Oct 21 1898

8. AGE: Years: 47 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: England. (Bournemouth)

(Town, county, and state)

10. Usual occupation: Home Trainer

11. Indusfry or business: Brick Wing farm

FATHER — 12. Name: Frederick Barrow

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Foooo Not Known

MOTHER — 15. Birthplace: England

16. Informant: Mrs Mary G. Barrow

Address: Monkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13 45 (month) (day) (year)

Cemetery or crematory: Bethel

Location: Madonna Md. Harford Co.

18. Funeral director: Martin Glentz

Address: Jarrettsville Md.

Sept 13 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 45 at 1 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

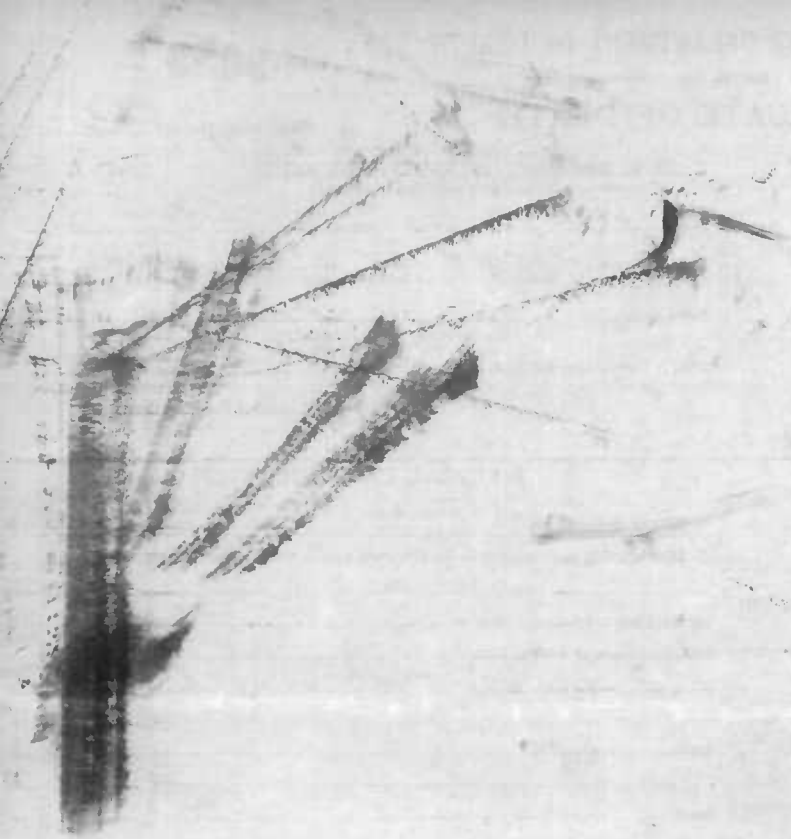
Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Deputy Medical Examiner for Harford County M. D. or other

Address: Bel Air Md Date signed: 9/9/45



IF NOT CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1226)

09056

CERTIFICATE OF DEATH

★ Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: (If outside city or town limits, write RURAL and give nearest town) Havre de Grace
How long in above place of death? 7 yrs.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 7 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Bel Air (If outside city or town limits, write RURAL and give nearest town)
Street No. 211 Bond St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jacob Bishop

3.(b) Social Security Number:

4. Sex: M
5. Color or race: Negroe
6.(a) Single, married, widowed, or divorced: married
8.(b) Name of husband or wife: Katie Bishop
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 3/20/61
8. AGE: Years: 84 Months: 6 Days: 20 If less than one day: hrs. min.
8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Unknown
FATHER 13. Birthplace: "
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: "
18. Informant: Katie Bishop
Address: Bel Air, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11/45 (month) (day) (year)
Cemetery or crematory: Hendon Hill
Location: Near Bel Air, Md
18. Funeral director: Dean & Foster
Address: Bel Air, Md
19. Sept-9 (Date rec'd by registrar) 18. VS- A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1945 at 5 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 1945 to Sept. 9 1945
and that I last saw him alive on Sept. 9 1945

Immediate cause of death	DURATION
Acute Heart Failure	
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Intestinal obstruction, Cancer, Incomplete (Probably due to Cancer)	Indeterminate

(Include pregnancy within 3 months of death) Cystic Ovary. Not Cancer. due to Cancer.

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. Reese Lewis M. D. or other
Address: Harford Memorial Hospital Date signed: 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

09057

★ Reg. Dist. No. 18 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural Bore de Brae R.D #1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~ 16 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Bore de Brae

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Greenspring

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Blaine

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Bessie Lipscomb

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 29 1883

8. AGE: Years	Months	Days	If less than one day
62	2		...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business

FATHER — 12. Name: Donald Blaine

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Bessie Blaine

Address: Bore de Brae R.D #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8-45 (month) (day) (year)

Cemetery or crematory: Green Spring

Location: Level Harford Co Md.

16. Funeral director: Henry F. Fanning & Sons.

Address: Aberdeen Md.

19. Sept 8 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1945 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1942 to Sept 6 1945 and that I last saw him alive on Sept 5 1945

Immediate cause of death	DURATION
Chr Myocardial Disease	3 yrs.
Due to	
Due to	
Other conditions: Chr. Prostate Hypertrophy (Include pregnancy within 3 months of death)	3

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md. Date signed: 9/6/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09058

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Perry Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1183 4th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carl Allen Bond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Mar. 27, 1945

8. AGE:

Years	Months	Days	If less than one day
0	6	6	— hrs. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation —
11. Industry or business —

FATHER
12. Name Harry Philmore Bond
13. Birthplace Md.

MOTHER
14. Maiden name Lida Taylor
15. Birthplace Md.

16. Informant Mr. Harry P. Bond
Address 1183 4th St. Perry Point Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30, 1945 (month) (day) (year)
Cemetery or crematory Forest Hill
Location Harford Co., Md.

18. Funeral director J. Madison Mitchell
Address Havre de Grace, Md.

19. Sept. 28 19 45 C. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 19 45 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 28 19 43, to Sept. 28 19 45 and that I last saw h... alive on Sept. 28 19 45

Immediate cause of death	DURATION
Acute Colitis	
Due to Dehydration	
Due to Toxemia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Lewis M.D. M. D. or other
Address Havre de Grace, Md. Date signed 9-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9059

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Yrs
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in Hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Conowingo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ira Brantner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Annie Brantner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-21-92

8. AGE: Years	Months	Days	If less than one day
53	5	2	..... hrs. ..... min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Fireman at Bainbridge

FATHER
12. Name Jacob Brantner
13. Birthplace Bedford Co. Pa.

MOTHER
14. Maiden name Anna Wilkins
15. Birthplace Bedford Co. Pa.

16. Informant Mrs Hazel Medley
Address Conowingo Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27 1945 (month) (day) (year)
Cemetery or crematory Baptist Cem.
Location Conowingo Md.

18. Funeral director J. E. Tyson
Address Rising Sun, Md.

19. Sept. 23 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1945 at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1945, to ..... 19..... and that I last saw him alive on Sept 23 1945

Immediate cause of death	DURATION
Cardiac insufficiency	
Due to Bilateral Lobar pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Havre de Grace Md. Date signed 9-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on ..

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

09060

File No. G98 OCT 9 1945

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hour
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..
(If rural, give LOCATION)
2.(a) If veteran, name war ..

3. (a) FULL NAME Marcelline Christy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Negro	Single

6.(b) Name of husband or wife ..
6.(c) If alive, give age ..years

7. Birth date of deceased (mo., day, yr.) December 18 1889

8. AGE: Years	Months	Days	If less than one day
55 56	9	11	..hrs. ..min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation ..
11. Industry or business ..

FATHER
12. Name Nelson Christy
13. Birthplace Virginia

MOTHER
14. Maiden name Martha Clark
15. Birthplace Virginia

16. Informant Blanche Christy - Daughter-in-law
Address Aberdeen, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10-1945 (month) (day) (year)
Cemetery or crematory Union M. E.
Location Near Aberdeen Md
18. Funeral director Henry Fanning Sons
Address Aberdeen Md.

19. 9-9 1945 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1945, at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1945, to Sept 7 1945 and that I last saw h.. alive on Sept 6 1945

Immediate cause of death	DURATION
Organic Stenosis	1 Day
Due to Chronic Myocarditis	
Due to	
Other conditions Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..Date of op. ..
Autopsy results ..
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..Date of ..
Where did injury occur? ..
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ..
Means of injury Injured at work?

23. SIGNATURE James Corbett M D
M. D. or other
Address Havre de Grace Md Date signed Sept 7 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

VS A15

69661

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (120-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air, Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Philip H Close

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elise W. Close

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 17-1869

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: St Clairsville Ohio (Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business

FATHER — 12. Name: Joseph H Close

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Sara B Adams

MOTHER — 15. Birthplace: Md

18. Informant: Miss Ariel Close

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2/45 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Emmorton

18. Funeral director: Deaver & Seals

Address: Bel Air Md

19. 10-2-45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 19 45, at 9 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 30, to Sept 19 45

and that I last saw him alive on Sept 30 19 45

Immediate cause of death	DURATION
Myocardial failure (terminal)	
& Colitis	
Due to: Hypertension & senility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W B Hopkins M. D. or other

Address: Bel Air Md Date signed Oct 1-1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

09662

CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH:
County Harford.
City or town Rural Bel air Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27
Hospital, Institution, or street address where death occurred:
Home - Safford Furnace.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Rural Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Safrd Furnace
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Rudolph Cullum.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mattie M. Bill
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 4 1884

8. AGE: Years	Months	Days	If less than one day
61	2	9	...hrs. ...min.

9. Birthplace Hartford C. Maryland.
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business Dairy
FATHER 12. Name Henry Cullum.
13. Birthplace Hayford Co. Md.
MOTHER 14. Maiden name Rebecca Williams
15. Birthplace
16. Informant Rudolph Cullum Rt. 1
Address Bel Air, Md.
17. Burial Date thereof Sept. 16-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Babers
Location Aberdeen Md.
18. Funeral director Henry Tavenner Sons
Address Aberdeen Md
19. Sept. 15 1945 Nellie J. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13th 1945 at 10:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Sept 13 1945
and that I last saw h... alive on Sept 13 1945

Immediate cause of death	DURATION
Arterio Sclerosis	
Angina	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.
M. D. or other
Address Havre de Grace Md. Date signed 9/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09663

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Denby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife William Denby
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 9. 1881

8. AGE: Years 64 | Months 5 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Harford Co Maryland
(Town, county, and state)

10. Usual occupation Domestic Servant

11. Industry or business

FATHER
12. Name Joseph Robinson
13. Birthplace Maryland

MOTHER
14. Maiden name Tamer Evans
15. Birthplace Maryland

16. Informant Lottie V. Chase
Address Magnolia Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 16 1945 (month) (day) (year)
Cemetery or crematory Baptist
Location Magnolia Md

18. Funeral director Howard R. McCormack
Address Aberdeen Md

19. Sept 15 1945 (Date rec'd by registrar) Marie M Mouldsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1945 at 3.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to Sept 13 1945
and that I last saw h on alive on Sept 12 1945

Immediate cause of death	DURATION
Cancer of breast with metastases	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Cancer of breast Date of op. 1943 June

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred O Hodous, M.D.
M. D. or other
Address Edgewood Md Date signed Sept 13 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (54)

CERTIFICATE OF DEATH

(9064)

Reg. Dist. No. 183

1. PLACE OF DEATH:

County Harford

City or town Harrisville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford

City or town Harrisville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Webster B Edie

3. (b) Social Security Number None

4. Sex: Male / ~~Female~~

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Carl Edie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9 1879

8. AGE: Years 66 | Months 6 | Days 24 | If less than one day: hrs. ..... min.

9. Birthplace Yorklyn Del (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name Arthur Edie

FATHER 13. Birthplace York Co Pa

MOTHER 14. Maiden name Letitia Burns

MOTHER 15. Birthplace Chesterco Pa

16. Informant Royston Edie

Address Stewartstown Pa

17. Burial, cremation, or removal. Which? Burial Date thereof Oct 3 1945 (month) (day) (year)

Cemetery or crematory Norrisville

Location Norrisville Md

18. Funeral director H Norman Kirk

Address Forest Grove Pa

Oct 3 1945 (Date rec'd by registrar) Thomas P Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945, at 3.0 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 1945 to Sept. 30 1945

and that I last saw h alive on Sept. 29 1945

	DURATION
Immediate cause of death Chronic Myocarditis	
Due to Chr. Passive Congestion.	
Due to Bronchial Asthma (Chronic)	
Due to Emphysema	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ramon H. Gemmill M. D. or other

Address Stewartstown, Pa Date signed Oct. 1, '45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09065

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-c)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 188

1. PLACE OF DEATH:

County Harford

City or town Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 9 mos.

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? 5½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State North Carolina County - -

City or town Ashville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Tieman Street
(If rural, give LOCATION)

2.(a) If veteran, name war World War II ✓

3. (a) FULL NAME

EISON, HARRY

3. (b) Social Security Number

34458525

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	N	Married

B.(b) Name of husband or wife Essie Eison

6.(c) If alive, give age - - years

7. Birth date of deceased (mo., day, yr.) 20 January 1913

8. AGE: Years	Months	Days	If less than one day
32	7	21	....hrs. ....min.

9. Birthplace Union, S. C.
(Town, county, and state)

10. Usual occupation Soldier

11. Industry or business U.S. Army

FATHER 12. Name - -

13. Birthplace Union County, S. C.

MOTHER 14. Maiden name Iola C. Coleman

15. Birthplace - -

16. Informant Service Record

Address - -

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9/13/45 (month) (day) (year)

Cemetery or crematory St. Lukes Cemetery

Location Whitmire, South Carolina

18. Funeral director Elmer E. Bullock

Address 536 Lewis St. Honesdale, Pa.

19. 9 September 1945 (Date rec'd by registrar) Marie M. Mead Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 September 1945 at 2305 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 September 1945 19.... to .... 19....

and that I last saw him alive on 10 September 1945 19....

Immediate cause of death	DURATION
Pulmonary Edema	5½ hours
Due to alcoholism Acute	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations - - Date of op. ....

Autopsy results not yet known

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - - Date of - -

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE Harry Weintraub M. D. or other

Address Station Hospital, Edgewood Arsenal, Md. Date signed 11 Sept 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09066

CERTIFICATE OF DEATH

Reg. Dist. No. 184

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Harford
City or town Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Cleveland Ellis

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1945

8. AGE: Years | Months 2 | Days 28 | If less than one day hrs. min.

9. Birthplace Harford Co., Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER 12. Name Govin Ellis
13. Birthplace Ash Co., N.C.

MOTHER 14. Maiden name Lulla Blevins
15. Birthplace Ash Co., N.C.

16. Informant Mr. Govin Ellis
Address Level, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 3 1945 (month) (day) (year)
Cemetery or crematory Franklin Cem
Location Harford Co, Md

18. Funeral director H. L. Bailey
Address Darlington, Md.

19. Sept. 2 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31 1945 to Sept 1 1945 and that I last saw h... alive on Sept 1 1945

Immediate cause of death	DURATION
Colitis	16 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation —
Date of op.
Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W E Gallion M. D. or other
Address Darlington Md Date signed 9-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

09067

CERTIFICATE OF DEATH

★ Reg. Dist. No. 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Harford
City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Joppa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Frank Fiskel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Annie R. Enow

6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) May 23 1864

8. AGE:	Years	Months	Days	If less than one day
	81	4	16	...hrs. ...min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER 12. Name David Fiskel

13. Birthplace Pa

MOTHER 14. Maiden name Caroline

15. Birthplace

16. Informant Mrs. R. O. Barnett

Address Joppa Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 2-1945 (month) (day) (year)

Cemetery or crematory Wiseburn

Location White Hall Md

18. Funeral director Howard S. Mathews

Address White Hall Md

19. Sept 30 1945 (Date rec'd by registrar) Marie M. Mouksdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1944 to Sept 29 1945

and that I last saw him alive on Sept 29 1945

Immediate cause of death	DURATION
Bronchopneumonia	1 Wk
Due to	
Due to	
Other conditions Prostatic Hypertrophy 3 yrs Myocardial Degeneration 10 yrs	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gilford F. Hudson M.D.
M. D. or other

Address Fork Md Date signed 9/30/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

69668

Reg. Diat. No. 185-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Box 74 (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Hash

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Child

6.(b) Name of husband or wife None
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1, 1945

8. AGE: Years	Months	Days	If less than one day
Newborn			1 hrs. 30 min.

9. Birthplace Havre de Grace Md (Town, county, and State)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Thomas Hash
FATHER 13. Birthplace Md.
MOTHER 14. Maiden name Hazel Collins
MOTHER 15. Birthplace N. Carolina
16. Informant Thomas Hash
Address Havre-de-Grace Md
17. Burial (Burial, ~~cremation, or removal~~ Which?) Date thereof Sept 2, 1945 (month) (day) (year)
Cemetery or crematory
Location Harford Co., Md.
18. Funeral director H. S. Bailey
Address Darlington - Md
19. Sept 4 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945, at 8:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Sept 1945 and that I last saw h[illegible] alive on Sept 1 1945

Immediate cause of death	DURATION
Premature birth	1 hrs.
Due to Acute pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Ralph Hartzler M. D. or other
Address Churchville Md Date signed Sept 4, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09069

Reg. Dist. No. 182

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Almira Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 28-1860

8. AGE: Years: 85 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Harford Co (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: John R Jackson
13. Birthplace: Balto., Co. Md

MOTHER
14. Maiden name: Hannah Pardue
15. Birthplace: Harford Co., Md

16. Informant: Mrs. Benton Gross
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 19/45 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Near Jarrettsville Md

18. Funeral director: Dean & Foster
Address: Bel Air

19. 9 18 1945 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17, 1945 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1924 to 1945
and that I last saw h[illegible] alive on Sept 13 1945

	DURATION
Immediate cause of death: Myocardial Failure	
Due to: Hypertension - Myocarditis	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W B Hopkins M. D. or other
Address: Bel Air Md Date signed: 9/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

09670

CERTIFICATE OF DEATH

Reg. Dist. No. 182

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Near Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kelly Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 17 - 1903

8. AGE:

Years	Months	Days	If less than one day
42			..... hrs. ..... min.

9. Birthplace: Trappe Hill, N.C.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: A James Johnson

13. Birthplace: N.C.

MOTHER

14. Maiden name: Effie Sparks

15. Birthplace: N.C.

16. Informant: Eugene M Johnson

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 5/45 (month) (day) (year)

Cemetery or crematory: Mt Zion Cemetery

Location: Near Fountain Green, Md.

18. Funeral director: Deaver & Todd

Address: Bel Air, Md

19. 9-4 1945 Priscilla Fawwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot wound cerebrum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of 9/3/45

Where did injury occur? Bel Air (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Shot self Injured at work? no

23. SIGNATURE: Gerald C Palmer MD

M. D. or other

Address: Bel Air Md. Date signed 9/4/45

DEPUTY MEDICAL EXAMINER HARFORD COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (463) 4

CERTIFICATE OF DEATH

09071

★ Reg. Diat. No. 181

1. PLACE OF DEATH:

County Harford

City or town Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Md. Ave. Box Exp

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Bertha E. Jopp

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~wife~~ George L. Jopp

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Aug. 6th 1893

8. AGE: Years 52 | Months 1 | Days | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Thomas S. Poole

13. Birthplace Carroll Co Md

MOTHER 14. Maiden name Barbara Zellers

15. Birthplace Germany

18. Informant Mrs. George L. Jopp

Address Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24 1945 (month) (day) (year)

Cemetery or crematory Calvary M. E. Church

Location Bonsha Md

18. Funeral director Henry Farring Sons

Address Aberdeen Md.

19. Sept 24 1945 Nellie H. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1945, at 7:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945, to Sept 21 1945

and that I last saw h. alive on Sept 21 1945

Immediate cause of death	DURATION
Coronary thrombosis	1 day
Due to Hepatic Metastasis	6 mos.
Due to Carcinoma of Stomach	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed Sept 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162C

CERTIFICATE OF DEATH

09072

Reg. Dist. No. 181

1. PLACE OF DEATH:
County Harford
City or town Aberdeen Proving Ground
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Aberdeen Proving Ground
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Flonnie Amelia Lawes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	widowed

6.(b) Name of husband or wife George Herbert Lawes
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 10 1865

8. AGE:	Years	Months	Days	If less than one day
	79	10	2	..... hrs. ..... min.

9. Birthplace Birmingham England
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name George Metcalfe
13. Birthplace England

MOTHER
14. Maiden name Amelia Speers
15. Birthplace England

16. Informant Herbert L. Lawes
Address Aberdeen Proving Ground

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 17/45 (Month) (day) (year)
Cemetery or crematory Lakewood Cemetery
Location Minneapolis, Minn.
18. Funeral director John O. Mitchell & Sons
Address 1660 Eustace Place

19. 9/14 1945 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to 12 Sept 1945 and that I last saw h.. alive on 12 Sept 1945

Immediate cause of death	DURATION
Senility	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. C. Harvey, Col. M.C. M. D. or other
Address Aberdeen Pr. Gr. Md. Date signed 12 Sept 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09073

Reg. Dist. No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel W. Peters

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Hazel C Woods Peters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 30/1901

8. AGE:

Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace: Va

(Town, county, and state)

10. Usual occupation: Lumber

11. Industry or business

FATHER 12. Name: Henry R Peters

13. Birthplace: Va.

MOTHER 14. Maiden name: Zula E Thomas

15. Birthplace: Va.

16. Informant: Mrs Hazel W Peters

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16/45 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green Harford Co

18. Funeral director: Dean & Foster

Address: Bel Air Md

19. 9-15 1945 Priscilla Cromwell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1945 at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 - 1945, to Sept 13 1945 and that I last saw h.. alive on Sept 13 1945

Immediate cause of death	DURATION
TUMOR OF BRAIN:	7
Malignant Cyst O.P.	
Due to Duration: 4 years	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md Date signed 9/15/45

09074

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Street Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
~~City~~ or town: Street Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3. (a) FULL NAME Evans E. Sadler

3. (b) Social Security Number No

4. Sex	5. Color or race	6. (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of husband or wife: Lorraine Sadler
Alive 6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 17, 1866

8. AGE:

Years	Months	Days	If less than one day
79	6	4	hrs. min.

9. Birthplace: Harford Co., Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Farmwork

FATHER
12. Name: Wm. H. Sadler
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Rebecca Andrew
15. Birthplace: Harford Co., Md.

16. Informant: Mr. Wm. Sadler
Address: Street, Md. R. D.

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof Sept 23 1946 (month) (day) (year)
Cemetery or ~~crematory~~: Darlington Cem.
Location: Harford Co. Md.

18. Funeral director: H. E. Bailey
Address: Darlington, Md.

19. Sept 22, 1946 M. W. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw him alive on About August 30 1946

Immediate cause of death: Hypostatic pneumonia	DURATION
Due to: Arteriosclerosis,	
Due to: Senile debility	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Benjamin Sowers M. D. or other
Address: Cardiff, Md. Date signed Sept 22, 1946

09075

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 180

1. PLACE OF DEATH:
County: ~~Otter Point Station~~ Harford
City or town: Otter Point Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? unknown
Hospital, Institution, or street address where death occurred:
Otter Point Station
How long in hospital or institution? dead on arrival at hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Massachusetts County: —
City or town: Fall River
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 71 East Maine Street
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3. (a) FULL NAME: ST. DENIS, LEOPOLD

3. (b) Social Security Number: #014-01-3931

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Anita St. Denis
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1 October 1918

8. AGE: Years	Months	Days	If less than one day
26	11	16	...hrs. ...min.

9. Birthplace: Fall River, Massachusetts (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U.S. Army

FATHER
12. Name: Philias St. Denis
13. Birthplace: —

MOTHER
14. Maiden name: Marie L. (maiden name not known)
15. Birthplace: —

16. Informant: Service Record
Address: U.S. Govt.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1945 (month) (day) (year)
Cemetery or crematory: Boyle Funeral Home
Location: Fall River, Mass.
18. Funeral director: Howard K. McCormack
Address: Abingdon Maryland

19. Sept. 18 1945 (Date rec'd by registrar) Marie M. Mouldale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 17 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from did not see him alive 19..., to ...19...
and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Shock	
Exposure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: Fract 3rd R. b. lt. Hemmorhage Pleural
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident ? Date of 17 Sept 45
Where did injury occur? otters Pt. (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Penna R.R.
Means of injury: Fall from train Injured at work? no

23. SIGNATURE: Ed S. Keller
...B. KELLER, JR., Capt. MC M. D. or other
Address: Edgewood Arsenal, Md. Date signed: 17 Sept 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09076

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 181

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Havre de Grace Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME Isaac Stewart

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Euphemia Stewart
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 10, 1858

8. AGE: Years 86 | Months 8 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Kent Co, Md.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Carpenter
FATHER 12. Name Wm. Stewart
13. Birthplace Kent Co, Md.
MOTHER 14. Maiden name Maria Brenner
15. Birthplace Kent Co, Md
16. Informant Mrs. Isaac Stewart
Address Havre de Grace, Md. R.D.
17. Burial (Burial, cremation, or removal) Which?) Date thereof Sept 9 1945 (month) (day) (year)
Cemetery or crematory Fatherwell Cem,
Location Cecil Co, Md.
18. Funeral director H. S. Bailey
Address Darlington Md.
19. Sept 7 1945 (Date rec'd by registrar) Bertha B. Knight Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945; at 10 15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945 to Sept 6 1945
and that I last saw him alive on Sept 5 1945

Immediate cause of death	DURATION
Myocarditis	15 Yrs
Due to	
Due to	
Other conditions Gangrene L Left foot	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. E. Galleon M. D. or other
Address Darlington Date signed 9-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

09077

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Sarah Ann Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: Edward J. Thompson
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 2. 1848

8. AGE: Years	Months	Days	If less than one day
97	7	1	hrs. min.

9. Birthplace: Newport Campbell co Kentucky
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: John Purser
13. Birthplace: Ireland, county Mayo

MOTHER
14. Maiden name: Eliza Dunlap
15. Birthplace: Ireland, County Fermanagh

16. Informant: Edmund Thompson
Address: Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9. 7. 45 (month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Newport Kentucky

16. Funeral director: Martin Gluck
Address: Jarrettsville Md.

19. 9-4 1945 (Date rec'd by registrar) Priscilla Foxwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945 at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 3 1945
and that I last saw her alive on Sept 1 1945

Immediate cause of death	DURATION
Hypostatic Pneumonia	3da.
Due to: Chr Myocardial Disease	>
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 9/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09078

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Wm. A. Grantner

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 3, 1865

8. AGE: Years 79 | Months 11 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Saw Mill Cook

FATHER
12. Name: David Grantner
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Jane Jones
15. Birthplace: Harford Co., Md.

16. Informant: Mr. Harry Comer
Address: Darlington, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11, 1945 (month) (day) (year)
Cemetery or crematory: Dublin Cem
Location: Harford Co., Md.

18. Funeral director: H. S. Bailey
Address: Darlington, Md.

19. Sept. 9 19 45 M. E. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1945, at 6. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Sept 8 1945
and that I last saw him alive on June 1 1945

Immediate cause of death	DURATION
Sues	25 yrs
Due to	
Due to Tabes dorsalis	—
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. E. Gallion M. D. or other
Address: Darlington, Date signed: 9-10-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(no 2)

19079

Reg. Diat. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Near Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? accident
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Rural - Street
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Scarborough's Corner
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Myrtle Elizabeth Waddell

3. (b) Social Security Number: 214-26-1011

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Ambrose Waddell
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Jan. 6. 1909

8. AGE:

Years	Months	Days	If less than one day
36	8		hrs. min.

9. Birthplace: Laurel Springs N.C. Ashe Co.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Alexander Perins
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Martha J. Smeathe
15. Birthplace: North Carolina
16. Informant: Mr. John Perins
Address: North East, Md.
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1945 (month) (day) (year)
Cemetery or ~~crematory~~: North Bilkesboro
Location: North Bilkesboro
18. Funeral director: Henry Jarvis & Sons
Address: Aberdeen, Md.
19. Sept 16 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1945, at 7P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 9/14/45
Where did injury occur? Harford Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) U.S. Route 40
Means of injury: Hit by car Injured at work? no

23. SIGNATURE: Gerald C Palmer M D
Deputy Medical Examiner
Harford County M. D. or other
Address: Bel Air, Md. Date signed: 9/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

19680

★ Reg. Dist. No. 18 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Jane Williams

3.(b) Social Security Number Lost in fire

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife Otto B. Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1905

8. AGE: Years 39 | Months 11 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace Harford County Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Daniel Johnson
13. Birthplace Harford County Md

MOTHER 14. Maiden name Sarah Pierce
15. Birthplace Harford County Md.

16. Informant Mrs. Otto B. Williams
Address Aberdeen, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 27 45 (month) (day) (year)

Cemetery or crematory Union Methodist
Location Sugar Creek, Maryland

18. Funeral director Elmer E. Bellert
Address 55 Lewis St. Havre de Grace

19. Sept 27 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1945 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Burned to death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/24/45
Where did injury occur? Aberdeen (City or town) Harford (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury House burned Injured at work? no

23. SIGNATURE Gerald C. Palmer M.D.
Deputy Medical Examiner
M. D. or other
Address Bel Air, Md. Date signed 9/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

09081

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Level
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Level
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Littleton Green Worthington

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth B. Worthington
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): December 1 1884

8. AGE: Years	Months	Days	If less than one day
60	9	1	hrs. min.

9. Birthplace: Havre de Grace, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: William C. Worthington
13. Birthplace: Havre de Grace
MOTHER 14. Maiden name: Louisa Green
15. Birthplace: Havre de Grace
16. Informant: Elizabeth B. Worthington
Address: Level, Harford, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6 1945 (month) (day) (year)
Cemetery or crematory: Churchville Presbyterian
Location: Churchville, Md.
19. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. Sept 5 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945, at 3:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Died suddenly 19
and that I last saw h.... alive on August 10 1945
Immediate cause of death: Cardiac Angina — DURATION: Death occurred instantly
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: W. E. Gallion, M. D., or other
Address: Darlington Date signed: Sept 4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CITIES CORPORATE LIMITS ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

19182

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred: 220 So. Stokes, St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 220 So. Stokes
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME William James Wright

3.(b) Social Security Number no?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Laura V. Wright
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan. 29 1871

8. AGE:

Years	Months	Days	If less than one day
74	7	28	— hrs. — min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Wm Henry Wright
13. Birthplace Md.

MOTHER
14. Maiden name Mary Curry
15. Birthplace Md.

16. Informant Mrs. Laura V. Wright
Address 220 So. Stokes St. City.

17. Burial Date thereof Sept. 30, 1945
(Burial, cremation, or removal—Which?) (month) (day) (year)
Cemetery or crematory Rock Run
Location Harford, Co.

18. Funeral director R. Madison Mitchell
Address Havre de Grace, Md.

19. Sept. 28 1945 C. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1945, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to Sept 27 1945 and that I last saw h... alive on Sept 27 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to arterio sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Irwin Corbett M.D.
M. D. or other
Address Havre de Grace Date signed 9-28-45